West Virginia Orthopaedic Society

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No Bones About It

Healthcare Debate:
The 800-lb gorilla no one discusses

President Greg Krivchenia, M.D. and Clint Welch, J.D.

On June 24, by a vote of 417-1, the House of Representatives passed H.R. 3962, the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act, which contains a fully paid for six-month SGR "fix." The legislation, which the Senate passed by unanimous consent on June 18, 2010, provides a 2.2 percent increase in reimbursement levels for claims for services provided on or after June 1, 2010 through November 30, 2010. This fix would apply retroactively to all claims submitted on or after June 1, 2010 thereby eliminating the 21 percent cut that became effective June 18, 2010. CMS will soon release specific details on how they will re-process claims.

With the passage of the Patient Protection and Affordable Care Act, health care is becoming ever closer to a government funded "right". As with any right, it has to have responsibilities attached. The Declaration of Independence should have read "…life, liberty, and the pursuit WITH RESPONSIBILITIES."

Patients have to be responsible for their own health and well being. They have to also be responsible for the consequences of their behavior and choices. Unfortunately there is currently no incentive in our health care system to take responsibility for one's own health. Much of this is due to the disconnect between the patient and the ultimate payor. Now with an additional 30 million lives added to the healthcare roles, even more patients will become disconnected to the cost of healthcare services.

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Jack R. Steele, M.D.

AAOS Councilor's Report Given

It is highly unlikely that physicians in specialty practice will be able to meet the HITECH "all or nothing" requirements.

The AAOS National Orthopedic Leadership Conference in Washington, D.C. concluded May 1, 2010 (April 28 – May 1). Diane Slaughter, Greg Krivchenia, Joe Prud'homme and I participated. I will summarize the major topics we presented to our congressional staffers. We were unable to meet face to face with any of our representatives this year. This was a combination of congressmen being on the floor voting or out of town campaigning.

I. Medicare Physician Payment Formula

This is based on the sustainable growth rate formula (SGR) enacted in the 1997 Balance Budget Act. When Medicare costs exceeded the projected growth as set by the SGR Formula, cuts to the program must be made. The net effect has been further cuts in payments. Of interest is, there have been no payment increases since 1992.

No congressman likes this formula but no permanent solution appears eminent. Temporary delays in implementation of the mandated 21% cut are in effect until June 1, 2010.

Senator Rockefeller's staff person as well as others predicted a 5-year freeze on Medicare payments to providers. The net effect in 5 years will be a 32 to 35% cut. Keep your eyes open for email political action updates from the Academy as June 1 is the next deadline. The AMA and American College of Surgeons are in support of this proposal. The Academy remains opposed but no other alternative is on the table.

II. HITECH Bill

This is part of the 787 billion American Recovery and Reinvestment Act of 2009 (ARRA).

This HITECH Act also established an incentive program for physicians to adopt HIT in their practices. To gain more use of the electronic medical record (EMR) technology, the Act provides financial incentives to physicians and other providers who are "meaningful users" of HIT early on (2011 – 2014) and penalties (beginning in 2015) for those who did not adopt in later years. The area of meaningful use of EMR technology has become a significant issue for AAOS and other medical associations.

The AAOS supports the goal of health information technology and believes: 1) An electronic medical record in a physicians office

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Ali Oliashirazi and Bill Sale

Haitian Need Great: Please Help

Dear Colleagues,

In a nutshell, Haiti redefines poverty. A devastating earthquake has compounded the plight of this poor country. As you have seen in the media and for those of you who saw it first hand, the absolute lack of every necessity, including drinkable water, food, housing, medicine, and safety, is unparalleled in the western hemisphere. Now that this country is out of the limelight, they will most likely quickly fall back into the same abyss.

As you know, the WVOS board approved $5,000 to help purchase the Surgical Implant Generation Network (SIGN) femoral/tibial nail system to be placed in Hospital Sacra Coure in Milot, Haiti, a Haitian hospital that is frequently visited by Drs Sale, Sibley and other WVOS members. This hospital in Northern Haiti played a major role in treating earthquake casualities. The initial cost of the instruments and basic IM nail set was about $15,000. This NON-PROFIT SIGN company will replace any inventory used at NO CHARGE as it has done in other 3rd world countries.

To reduce the financial burden, the hope of the board was to solicit our membership to raise donations from the WVOS to offset this $5000 cost. Our goal is to have each ortho-paedic surgery member donate at least $50 toward this cause.

We often talk of Virchow's Triad when discussing DVT Propylaxis. Doctor Rudolf Virchow is actually better known for his advancement of public health in the late 1800's. I'd like to conclude by sharing a less known quote from this great man: "Medical education does not exist to provide students with a way of making a living, but to ensure the health of the community...physicians are the natural attorneys of the poor, and the social problems should largely be solved by them."

Thanks to all of you for your generosity.

Please send your TAX DEDUCTABLE check to WVOS ("Haiti Fund") today to help the people of this dispirited nation.

Haiti's absolute lack of every necessity is unparrelleled in western hemisphere.

The physician must meet all criteria to qualify for incentives.

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is important and helpful for patient care, patient safety, quality care, and measurement of outcomes. 2) HIT should strive to improve quality of care, not burden physicians.

In January of 2010, CMS proposed "meaningful use" criteria for physicians and other providers to meet in order to qualify for financial incentives. The AAOS believes the proposed criteria do not address specialty surgical practice. For example, all physicians would be required to submit vaccination records to an immunization data registry. In addition, the physician must meet all criteria to qualify for incentives. It is highly unlikely that physicians in specialty practice will be able to meet the "all or nothing" requirements established by CMS. As such, the AAOS would like CMS to allow specialty societies to develop specialty specific "meaningful use" criteria, and also that they eliminate the "all or nothing" requirement.

It should be noted that Kaiser-Permanente has spent over 4 billion dollars on EMR to date. Their system cannot meet this criteria.

III. IPAB

The Independent Payment Advisory Board (IPAB) is an appointed body with the jurisdiction to make decisions regarding Medicare reimbursement and coverage benefits. The establishment of this board delegates congressional authority over the Medicare program to an unelected and unaccountable board. The sole purpose of the IPAB is to contain Medicare costs which will likely subject physicians to continued cuts and reimbursement. Hospitals are exempt from any potential cuts the Board might make. This IPAB is specified in the "Patient Protection and Affordable Care Act". This is the newly enacted health care reform bill.

The IPAB will be comprised of fifteen members who will be appointed by the President and confirmed by the Senate. Members must be recognized as national experts in their fields in areas such as health policy, health economics and finance, and medicine. The Board must have, but is not limited to, physicians and health professionals. However, members may not engage in any other business, vocation, or employment, so any physician serving on the IPAB could no longer practice. Members terms are 6 years and may serve no more than two consecutive terms, however, they may be reappointed to two full consecutive terms to fill a

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Daryll C. Dykes, MD, PhD, Leadership Development Committee

AAOS Seeks Fellows 45 & Under

The Leadership Fellows Program (LFP) is a one-year program whose goal is to facilitate the development of future AAOS leaders. The LFP combines didactic leadership training with a mentoring program that matches the participants with an established leader.

Please Note: Those applicants unable to commit to attending the required LFP meetings should consider applying at a future time, as there are only a few meetings per year:

Annual Meeting - San Diego, CA

- LFP Sessions: Friday, February 18, 2011

Leadership Orientation - Rosemont, IL

- Thursday, March 24, to Saturday, March 26, 2011

National Orthopaedic Leadership Conference - Washington, DC

- Wednesday, April 6, to Saturday, April 9, 2011

The AOA Leadership Series – **Northwestern University, Evanston, IL**

- Date TBA, Friday – Sunday (TBD)

AAOS Fall Meeting – Seattle, WA

- Thursday, October 26, to Sunday, October 30, 2011.

Annual Meeing – San Francisco, CA

- LFP Sessions: Friday, February 10, 2012

LFP Site Visit:

- The LFP Fellows are allowed one site visit to their Mentor's institution (or the Mentor may visit the Fellow's institution) at the expense of the AAOS.

LFP Committee Assignments:

- As an LFP Fellow, you will be assigned to serve on an AAOS Committee.

Eligibility Requirements: Open to AAOS Fellows, 45 years or younger as of January 31, 2011. Only AAOS Fellows who meet the eligibility criteria should apply.

Instructions: Complete the online application at www.aaos.org/lfp and answer all questions fully and accurately. Incomplete applications will not be considered.

To be considered for the LFP include: (1) A completed application and (2) recommendations from two AAOS Fellows who have in-depth knowledge of your practice and leadership skills. These recommendations must be submitted to shapiro@aaos.org.

Deadlines: Application must be completed online and letters of recommendation provided to kramer@aaos.org by June 18, 2010. Selections will be made in August of 2010.

Fellows and Mentors will participate in LFP sessions on leadership, diversity, and media training.

Congress cannot make any changes to the proposal that repeal or change the IPAB without a 3/5 vote of the Senate.

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vacancy.

Thus appointed by the President, IPAB submits their proposals to the House Energy and Commerce Committee, House Ways and Means Committee, and Senate Finance Committee. The committees can consider amendments that further reduce costs, but cannot modify the original proposal in any way.

Congress cannot make any changes to the proposal that repeal or change the IPAB recommendations without a three-fifths vote of the senate. Prior to 2017, the law states, any changes to the IPAB requires a three-fifths vote of the senate.

The power of this appointed board is very significant. The staffs of the members of Congress we spoke with indicated their representatives did not particularly care for this section of the law. Specifically, Senator Byrd and reportedly House Speaker Pelosi are opposed to this as it does take power away from the Congress. Our Junior Senator, Jay Rockefeller, is the champion of the IPAB. He apparently was one of the writers of this. It remains to be seen where this section of the bill is headed. The AAOS is strongly opposed to the IPAB. You should also be aware that the person nominated to head up CMS is Donald Berwick, M.D., the Harvard public health researcher who wrote the scathing research on health care/health provider errors leading to deaths. He apparently is a protégé of Senator Rockefeller.

These three topics were the primary issues that we took to The Hill. We received reports from Massachusetts and also Canada on how their systems are working.

The presenters from Massachusetts included a private practice orthopedist in a four-man group practicing out of one hospital with a catchment area of about 120,000. The second orthopedist was a foot and ankle surgeon at Harvard.

The primary points from the Massachusetts Health Care Plan are as follows: 1) The number of uninsured patients in Massachusetts has decreased from 11% to 2.5%. 2) They have seen an approximate 30% decrease in patients without insurance which has increased access to care for that population. 3) Hospitals and physicians are receiving some reimbursement for services previously unpaid. 4) From an economic standpoint, health care reform has proven to be an unsustainable financial burden that poses a long

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Intern Meliss Dungey

Events Highlight WVOS Year

Two major events have highlighted the West Virginia Orthopaedic Society's (WVOS) year thus far, the National Orthopaedic Leadership Conference and the WVOS "MidSummer/ MidWinter" Meeting.

The National Orthopaedic Leadership Conference, sponsored by the American Academy of Orthopaedic Surgeons, took place April 28-30 in Washington, DC. President Greg Krivchenia, Vice President Joe Prud'homme, AAOS Councilor Jack Steel and Executive Director Diane Slaughter took this opportunity to visit with the West Virginia Congressional Delegation to voice their concerns about various issues affecting specialty surgical practice.

AAOS Councilor Jack Steel, MS, WVOS Vice President Joe Prud'homme, MD, and WVOS President Greg Krivchenia, MS, met with congressional staffers during the NOLC.

Due to Governor Manchin declaring a state of emergency in February, the MidWinter Meeting became the MidSummer Meeting on June 5 at the Marriott Town Center Hotel in downtown Charleston. The theme of this year's meeting with Athletic

West Virginia Association of Orthopaedic Executives' Secretary Clint Welch (left) and President David Proctor (right) visited with speaker James Perkins during lunch at the Marriott.

Injuries in Children and Adolescents. Presentations included benchmarking, as well as clinical issues. WVOS members and residents from Marshall University and West Virginia University presented. Physicians, athletic trainers, physical therapists, physician assistants and other allied health professionals had the opportunity to learn from and network with each other, as well as visit with the many exhibitors who attended.

Mark your calendars for March 5, 2011!

Mike McNicol, ATC, led a discussion on athletic trainers and their work with secondary school athletes.

Physicians and other allied health professionals had the opportunity to learn from each other.

It remains to be seen where this section of the bill is headed.

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term risk to the State of Massachusetts fiscal health. 5) The plan for cost containment that has recently been proposed involves the development of accountable care organizations (ACO). The ACO's will accept all or most all of the responsibility for the patient's care needs. ACO's are composed of hospitals, physicians, and/or other clinician and non-clinician providers. 6) The system requires patient centered care and a strong dependency on primary care. 7) There will be global payments and all payments to specialist physicians will pass through the primary care physician and ACO 8) The ACO/Global Fee System is expected to be in place by 2015.

The Canadian experience as I described from Brian Day in last year's councilor's report varied a bit from that presented at this meeting. The gentleman presenting at this meeting was an employed physician in Alberta British Columbia. He described a system whereby patients had relatively easy access to specialists and the wait time, in his opinion, was about 40 days for evaluation and scheduling for procedures. He also indicated that his payment was deposited directly in his bank account and that nearly 99% of physicians were represented by the Canadian Medical Association. There were, however, several speakers in the audience who had Canadian backgrounds or friends who practiced in Canada who noted that the wait time for total hips can be 18 months to 2 years. They also indicated that the best and brightest from Canada from a medical standpoint tend to gravitate to the United States for work. They felt that that was related to the system whereby the more you work, the more you are reimbursed. In Canada, apparently once the money runs out for the year in the specific province, then all elective procedures basically cease.

The Future of Health Care in America

These are my opinions today based on what I have heard over the last several days: 1) There will be a decline in the private practice of medicine. The trend nationally is hospital or academic employment of orthopedists. 2) Global or capitated payment for orthopedic services will most likely become a reality within the next 10 years. This would most likely follow the ACO format with primary care physicians determining the specialist's reimbursement. 3) There will be a necessary increase

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FTC Extends Enforcement Deadline for Identity Theft Red Flags Rule

At the request of several Members of Congress, the Federal Trade Commission is further delaying enforcement of the "Red Flags" Rule through December 31, 2010, while Congress considers legislation that would affect the scope of entities covered by the Rule. Today's announcement and the release of an Enforcement Policy Statement do not affect other federal agencies' enforcement of the original November 1, 2008 deadline for institutions subject to their oversight to be in compliance.

"Congress needs to fix the unintended consequences of the legislation establishing the Red Flags Rule – and to fix this problem quickly. We appreciate the efforts of Congressmen Barney Frank and John Adler for getting a clarifying measure passed in the House, and hope action in the Senate will be swift," FTC Chairman Jon Leibowitz said. "As an agency we're charged with enforcing the law, and endless extensions delay enforcement."

The Rule was developed under the Fair and Accurate Credit Transactions Act, in which Congress directed the FTC and other agencies to develop regulations requiring "creditors" and "financial institutions" to address the risk of identity theft. The resulting Red Flags Rule requires all such entities that have "covered accounts" to develop and implement written identity theft prevention programs to help identify, detect, and respond to patterns, practices, or specific activities – known as "red flags" – that could indicate identity theft.

The Rule became effective on January 1, 2008, with full compliance for all covered entities originally required by November 1, 2008. The Commission has issued several Enforcement Policies delaying enforcement of the Rule. Most recently, the Commission announced in October 2009 that at the request of certain Members of Congress, it was delaying enforcement of the Rule until June 1, 2010, to allow Congress time to finalize legislation that would limit the scope of business covered by the Rule. Since then, the Commission has received another request from Members of Congress for another delay in enforcement of the Rule beyond June 1, 2010.

The Commission urges Congress to act quickly to pass legislation that will resolve any questions as to

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Congress needs to fix the unintended consequences of the legislation establishing the Red Flags Rule.

The practice of medicine will change dramatically.

Anybody can poison himself who wants to and the taxpayers will pay for it.

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in use of ancillary providers for initial evaluation and subsequent referral of patients to orthopedists. This will include physician's assistants and nurse practitioners. They are cheaper to employ and can be trained in a much shorter time than a physician or orthopedic surgeon. 4) There will be more patients covered, therefore, there will be many more patients seeking care. 5) There will be more requirements for documentation for authorization of procedures. There will be also much closer scrutiny on outcomes of treatment by specific physicians. 6) There will be increased emphasis on treatment outcomes which will affect reimbursement.

In summary, the practice of medicine will change dramatically over the next 10 to 15 years. The Academy is working to keep up with the changes and to influence the outcomes to the benefit of our patients and ourselves.

It is critical that orthopedists keep up with the changes by reading the AAOS Now monthly magazine and also following the advocacy section on the AAOS website. The political action committee is also a tremendous source of information and is a critical component of our ability to influence the legislative aspect of our practices. I again suggest that you consider joining the AAOS Orthopedic PAC.

I will do my best to keep you informed as to the future and if you have any questions, please feel free to contact me.

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As this trend continues, we as orthopaedic surgeons will bear more of the burden at our expense. The government is forcing us to become more responsible for the health of our patients while rewarding irresponsible behavior. The current health care legislation did not effectively address this problem. It is the 800-lb gorilla in the corner of the room that legislators find easier to ignore than take a chance of offending constituents and losing reelection. As a source of inspiration, in 2007, West Virginia's Medicaid program decided to incorporate individual responsibility to improve the health of their population and lower costs. Enrollees who agree to certain stipulations, such as showing up to appointments on time, taking their meds, and avoiding the ER are rewarded with enhanced Medicaid benefits. Even though the initial results were mixed, the basic

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which entities are covered by the Rule and obviate the need for further enforcement delays. If Congress passes legislation limiting the scope of the Red Flags Rule with an effective date earlier than December 31, 2010, the Commission will begin enforcement as of that effective date.

In the interim, FTC staff has continued to provide guidance, both through materials posted on www.ftc.gov/redflagsrule, and in speeches and participation in seminars, conferences and other training events to numerous groups. The FTC also published a compliance guide for business, and created a template that enables low risk entities to create an identity theft program with an easy-to-use online form (www.ftc.gov/bcp/edu/microsites/redflagsrule/get-started.shtm). The FTC staff also has published numerous general and industry-specific articles, released a video explaining the Rule, and continues to respond to inquiries from the public. To assist further with compliance, FTC staff has worked with a number of trade associations that have chosen to develop model policies or specialized guidance for their members.

As was the case previously, this enforcement delay is limited to the Red Flags Rule and does not extend to the rule regarding address discrepancies applicable to users of consumer reports (16 C.F.R.§641), or to the rule regarding changes of address applicable to card issuers (16 C.F.R.§681.2).

For questions regarding this Enforcement Policy, please contact Naomi Lefkovitz or Pavneet Singh, Bureau of Consumer Protection, 202-326-2252.

The Federal Trade Commission works for consumers to prevent fraudulent, deceptive, and unfair business practices and to provide information to help spot, stop, and avoid them. To file a complaint in English or Spanish, visit the FTC's online Complaint Assistant or call 1-877-FTC-HELP (1-877-382-4357). The FTC enters complaints into Consumer Sentinel, a secure, online database available to more than 1,800 civil and criminal law enforcement agencies in the U.S. and abroad. The FTC's Web site provides free information on a variety of consumer topics.

The Commission has received another request from Members of Congress for another delay beyond June 1, 2010

David Proctor, ATC and Clint Welch, J.D.

Benchmarking Is Coming

As one doctor vowed to "learn more about the business of orthopaedics" following the MidWinter Meeting.

With recent healthcare legislation and changes in Medicare, it is more important than ever for administrators and physicians to have a firm grasp of their practice's financial position. An important step in improving the performance of an orthopaedic practice is benchmarking against others within a common geographical region.

Benchmarking, according to the AAOE, is important for the following reasons:

- Identify practices' strengths / weaknesses
- Improve operations
- Trim costs
- Enhance practice value
- Key to strategic planning

Below is a list of data points that could be gathered from member practices:

- Practice Demographics
- Number of FTE physicians and non-physicians
- Type of practice
- Number of office visits
- Revenue, expenses, and accounts receivable
- Gross billed charges
- Net collections
- Mid level provider charges and collections
- Total expenses
- Overhead percentages
- Personnel expenses
- Payer Mix

The benchmark survey which will be released later this summer will be accessed by members of WVOS and WVAOE through the WVOS website. Aggregated results will be shared with those completing the survey. Executives can retrieve a summary report that helps identify their practices' strengths and weaknesses, improve operations, trim costs, and enhance practice value. All data would be anonymous.

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premise was promising. Unfortunately, due to the new health care legislation, this program will end in September.

Hopefully the health care legislation will not be a substitute for lack of personal responsibility. Some in the public have already discovered that they no longer have to worry about paying their house, car, or credit card payment because the "government" will take care of it. My fear is that this methodology will create a growing mass of people that believe providing health care is someone else's problem and not their responsibility.

In closing, no meaningful health care reform will occur until someone addresses the 800-lb. gorilla in the room.